

PUBLIC SCHOOLS OF EDISON TOWNSHIP  
EDISON, NEW JERSEY 08837  
HEALTH SERVICES

**ROUTINE AND ATHLETIC PRE-PARTICIPATION PHYSICAL EVALUATION FORM**  
(To be completed by the examining physician, Grades 6-12)

**Part A: HEALTH HISTORY QUESTIONNAIRE**-Completed by the parent and student and reviewed by examining provider

**Part B: PHYSICAL EVALUATION FORM**-Completed by examining licensed provider with MD, DO, APN or PA

**Part A: HEALTH HISTORY QUESTIONNAIRE**

Today's Date: \_\_\_\_\_ Date of Last Sports Physical: \_\_\_\_\_

Student's Name: \_\_\_\_\_ Sex: M F (circle one) Age: \_\_\_\_\_ Grade: \_\_\_\_\_  
Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ School: \_\_\_\_\_ District: \_\_\_\_\_  
Sport(s): \_\_\_\_\_ Home Phone: (\_\_\_\_) \_\_\_\_\_  
Provider Name (Medical Home): \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

**EMERGENCY CONTACT INFORMATION**

Name of parent/guardian: \_\_\_\_\_ Relationship to student: \_\_\_\_\_  
Phone (work): \_\_\_\_\_ Phone (home): \_\_\_\_\_ Phone (cell): \_\_\_\_\_  
Additional emergency contact: \_\_\_\_\_ Relationship to student: \_\_\_\_\_  
Phone (work): \_\_\_\_\_ Phone (home): \_\_\_\_\_ Phone (cell): \_\_\_\_\_

**Directions:** Please answer the following questions about the student's medical history by circling the correct response. Explain all "yes" responses on the lines below the questions. Please respond to all questions.

1. Have you ever had, or do you currently have:

- |  |                    |
|--|--------------------|
| a. Restriction from sports for a health related problem?   | Y / N / Don't Know |
| b. An injury or illness since your last exam?  | Y / N / Don't Know |
| c. A chronic or ongoing illness (such as diabetes or asthma)?  | Y / N / Don't Know |
| (1.) An inhaler or other prescription medicine to control asthma?  | Y / N / Don't Know |
| d. Any prescribed or over the counter medications that you take on a regular basis?  | Y / N / Don't Know |
| e. Surgery, hospitalization or any emergency room visit(s)?  | Y / N / Don't Know |
| f. Any allergies to medications?   | Y / N / Don't Know |
| g. Any allergies to bee stings, pollen, latex or foods?  | Y / N / Don't Know |
| (1.) If yes, check type of reaction:   |                    |
| <input type="checkbox"/> Rash <input type="checkbox"/> Hives <input type="checkbox"/> Breathing or other anaphylactic reaction |                    |
| (2.) Take any medication/Epipen taken for allergy symptoms? (List below.)  | Y / N / Don't Know |
| h. Any anemias, blood disorders, sickle cell disease/trait, bleeding tendencies or clotting disorders?                         | Y / N / Don't Know |
| i. A blood relative who died before age 50?  | Y / N / Don't Know |

Explain all "yes" answers here (include relevant dates):

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List all medications here:

Medication Name	Dosage	Frequency

# History And Physical Form

**RJ Alexander**



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